29

29 Podiatrist

Podiatrists are enrolled only for services provided to QMB recipients or to recipients referred as a result of an EPSDT screening.

The policy provisions for podiatrists can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 11.

29.1 Enrollment

EDS enrolls podiatrists and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a podiatrist is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for podiatry-related claims.

NOTE:
All nine digits are required when filing a claim.

Podiatrists are assigned a provider type of 17 (Podiatrist). Valid specialties for podiatrists include the following:

- Podiatry (48)
- QMB/EPSDT (EQ)

Enrollment Policy for Podiatrists

To participate in the Alabama Medicaid Program, podiatrists must meet the following requirements:

- Possess a current license issued to practice podiatry
- Operate within the scope of practice established by the appropriate state's Board of Podiatry

29.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Podiatry services are covered only for services provided to QMB recipients or to recipients referred as a result of an EPSDT screening.

For more information regarding the EPSDT program, refer to Appendix A, EPSDT.

29.3 Prior Authorization and Referral Requirements

Podiatrists may provide services for QMB recipients or to recipients referred as a result of an EPSDT screening.

For podiatry services to be paid by Medicaid for non-QMB recipients (i.e., EPSDT), the service must be medically necessary and the result of a referral from a contracted Medicaid EPSDT screening provider. Screening providers will complete and forward an Agency Referral Form (form 362), which must identify the reason for referral and serve as documentation that the services provided were the result of an EPSDT screening.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39 to determine whether your services require a referral from the Primary Medical Provider (PMP).

29.4 Cost Sharing (Copayment)

The copayment amount is $1.00 per visit including crossovers. Copayment does not apply to services provided for pregnant women, nursing home residents, recipients less than 18 years of age, emergencies, and family planning.

The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

29.5 Completing the Claim Form

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Podiatrists who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

29.5.1 Time Limit for Filing Claims

Medicaid requires all claims for podiatrists to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

29.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

29.5.3 Procedure Codes and Modifiers

Podiatry providers use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

The (837) Professional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Podiatry CPT codes describing procedures performed on the foot and toes range from 28001 - 29909. In addition to the 28001-29909 CPT codes, podiatrists may also use the evaluation and management codes 99201-99215 and nail codes 11719-11765. Maximum units and prior authorization requirements should be checked through AVRS prior to rendering service. Refer to Appendix L, AVRS Quick Reference Guide, for more details on verifying this information.

29.5.4 Place of Service Codes

The following place of service codes apply when filing claims for podiatry services:

POS Code	*Description*
11	Office
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Center
31	Skilled Nursing Facility or Nursing Home
32	Nursing Facility
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
54	Intermediate Care Facility/Mentally Retarded
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic

29.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

29.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N